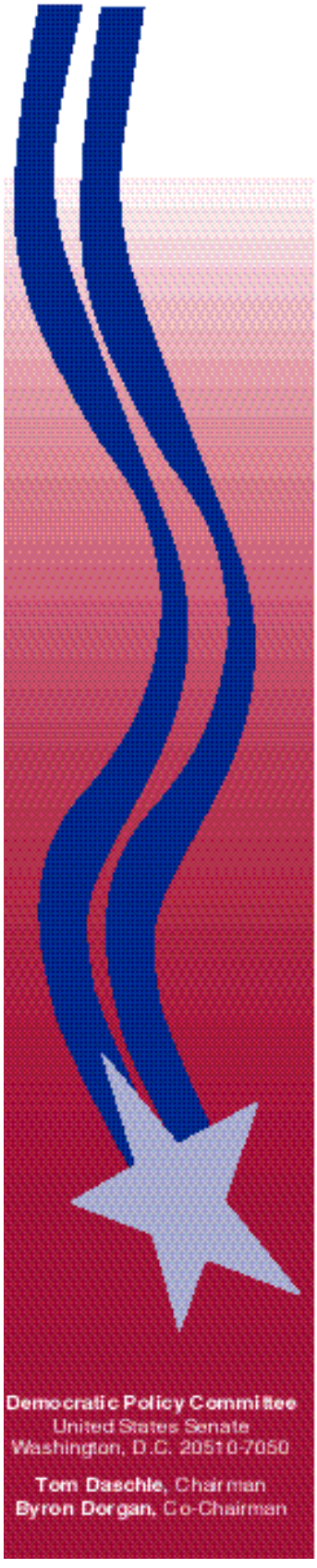
DPC

DEMOCRATIC POLICY COMMITTEE

FACT SHEET

FS-25-Health Staff Contact: Bonnie Hogue (202) 224-3232 June



Protecting the Doctor/Patient Relationship: Freeing Doctors to Practice Medicine

Freeing doctors to practice medicine. **S. 6**, the Democratic *Patients' Bill of Rights*, prohibits plans from arbitrarily interfering with a doctor's decisions regarding the manner or setting in which care is delivered, if that care is medically necessary or appropriate.

Our bill defines "medical necessity" as care consistent with generally accepted standards of professional medical practice. This provision would protect patients when an insurance company bureaucrat tells them they must have a medical procedure on an outpatient basis or be discharged from a hospital prematurely. Plans would no longer be able to deny promised benefits based on an interpretation of medical necessity defined by insurance companies rather than doctors. The easiest way for an HMO to protect profits is to deny care, even when the care is covered under the policy and recommended by the doctor.

- **S. 6** uses a professional standard of medical necessity—based on case law and standards historically used by insurance companies. Our definition of medical necessity is reasonable for both the plan and the patient because it is based on evidence in the particular case and general clinical standards. These definitions have evolved based on medical practice over the past 200 years.
- These provisions in **S. 6** have the support of the American Medical Association and nearly 200 other leading organizations that represent doctors, nurses, patients, working families and others.
- Without a fair definition of medical necessity, any bill to protect patients' rights will fall short of providing real protections. For example, if external reviewers must use an insurer's definition of medical necessity to resolve a dispute between doctors and insurers, the reviewers' hands will be tied.

- One managed care plan defines "medically necessary services" as "the shortest, least expensive, or least intense level of treatment, care or service rendered, or supply provided, as determined by us (the health plan), to the extent required to diagnose or treat an injury or sickness. The service or supply must be consistent with the insured person's medical condition at the time the service is rendered, and is not provided primarily for the convenience of the injured person or doctor."
- Our opponents will argue that our provision would allow physicians to order unnecessary care even if it is not appropriate for the patient. That is simply not true. Under our bill, an insurer can still challenge a doctor's recommendation, but their denial must be based on medical facts, not on their bottom line. Generally accepted principles of medical necessity include best medical evidence and the opinions of qualified doctors. We believe objective standards should determine what is medically necessary care.

Linda Peeno, a former claims reviewer, gave one example of the dire consequences our current system can have when she testified to the House Commerce Committee: she believes she caused the death of a man by denying him a necessary operation to save his heart. She said, "I was 'rewarded' for this … Like a skilled soldier, I was trained for this moment. When any moral qualms arose, I was to remember: I am not denying care; I am only denying payment."

Another case was that of Ethan Bedrick, who was born in 1992 with cerebral palsy. Ethan's doctor said that, with therapy, there was a 50-50 chance that Ethan might be able to walk. But his HMO cut off payment for the therapy because, they said, the odds of success weren't good enough to justify the cost. This change was recommended by an insurance company doctor performing a "utilization review" who never met Ethan or his doctors. That wasn't a medical decision—it was a business decision. And it was *wrong*.